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Civil Liability for the Use of Neck Restraints

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This is Part 2 of a two-part article. To read Part 1, click here.

❖ Correctional Settings

In *Graham v. Connor*, #87-6571, 490 U.S. 386 (1989), the U.S. Supreme Court held that all claims that law enforcement officers have used excessive force -- deadly or not – during the course of an arrest, investigatory stop, or other "seizure" of a free person are properly analyzed under the Fourth Amendment's "objective reasonableness" standard. The right to make an arrest or investigatory stop, the Court stated, necessarily carries with it "the right to use some degree of physical coercion or threat thereof to effect it." All the law requires is that it be a reasonable amount of force.

- A different set of rules apply to the use of force by correctional officers against convicted prisoners, based on the Eighth Amendment's prohibition of "cruel and unusual punishment." That is the legal standard that applies to the use of neck restraints, just like all other uses of force in a correctional context.

In *Whitley v. Albers*, #84-1077, 475 U.S. 312 (1986), the Court ruled that to show a violation of the Eighth Amendment in the context of attempting to quell a prison disturbance, the key question was whether the measures taken "inflicted unnecessary and wanton pain and suffering." That turns on whether the force was applied in a "good-faith

effort to maintain or restore discipline, or maliciously and sadistically for the purpose of causing harm."

The U.S. Supreme Court followed that decision up a number of years later with *Hudson v. McMillian*, #90-6531, 503 U.S. 1 (1992), which further refined the applicable legal standard. The U.S. Supreme Court rejected an additional requirement of "significant injury," reemphasizing the rule in *Whitley v. Albers* that the question is whether force was applied in a "good faith effort to maintain or restore discipline, or maliciously and sadistically to cause harm." This test, the Court stated, would apply regardless of whether the force was used in the context of a major prison disturbance, such as a riot, or a "lesser disruption."

It is true, the Court acknowledged, that the extent of the injury a prisoner suffers because of the use of force is one factor to be considered in deciding whether the force used was wanton and unnecessary, but there is no requirement to show a significant injury in order to assert a valid Eighth Amendment claim. Contemporary standards of decency, the Court reasoned, are always violated in the excessive force context when prison officials or employees maliciously and sadistically use force to cause harm, regardless of whether a significant injury occurs.

Both *Whitley v. Albers* and *Hudson v. McMillian* involved the use of force by prison staff members against convicted prisoners. What about the use of such force against pre-trial detainees in detention facilities, jails, or prisons? Such detainees are not protected by the Eighth Amendment prohibition on cruel and unusual punishment. Since they have not been convicted of any offense, they may not be subjected to any punishment at all without receiving due process of law. They are protected in the custodial context against the excessive use of force by the due process clause of the Fourteenth Amendment.

In a footnote in *Graham v. Connor*, the U.S. Supreme Court stated that the "due process clause protects a pre-trial detainee from the use of excessive force that amounts to punishment. After conviction, the Eighth Amendment serves as the primary source of substantive protection ... in cases ... where the deliberate use of force is challenged as excessive and unjustified. Any protection that substantive due process affords convicted prisoners against excessive force is, we have held, at least redundant, of that provided by the Eighth Amendment."

Any real distinction between the protection provided to pre-trial detainees and convicted prisoners has been largely "blurred" over the years by the courts, and the legal standard, technical pleading aside, is essentially the same.

The use of force in a sadistic and malicious manner for the purpose of doing harm is a fairly high standard and, when it does occur, can lead to criminal responsibility as well as civil liability. In *United States v. Gray*, #11-3143, 692 F.3d 514 (6th Cir. 2012), *cert. denied*, #12-7617, 133 S. Ct. 990 (2013), a correctional officer applied a "sleeper hold" to a pre-trial detainee, restrained in handcuffs and shackles, who continued to resist. The detainee had returned to the jail after being discharged by a hospital where he had been treated for some seizures.

The officer allegedly rendered the detainee unconscious using the hold, and failed to tell a nurse at the jail that he was "gurgling," followed by lying silent and motionless, and needed medical attention. A "sleeper hold," the court explained, occurs when a person wraps his forearm around the victim's neck in the crook of the person's arm. When performed correctly, the hold should cause the victim to temporarily lose consciousness. Performed incorrectly, it has the potential to inflict serious injury and even death.

In this case, after the application of the hold, other officers noted that the detainee was lying silent and motionless on the bed. The officer who applied the hold ordered them to leave. Despite a requirement in the facility that correctional officers were to seek medical attention any time force is used or an inmate was injured, the officer did not inform any medical personnel about the events that had occurred. Later, the detainee was discovered by a deputy doing rounds to be neither conscious nor breathing. Efforts to revive him were ultimately non-availing. He was declared brain dead, and was later removed from life support.

The officer was convicted of depriving the detainee of his rights and of obstructing a federal investigation into the detainee's subsequent death by falsifying documents. The evidence was sufficient to prove that the officer used force to put the detainee into a position requiring medical attention, and then acted with deliberate indifference towards his serious medical needs.

In *Burdine v. Sandusky County, Ohio*, #12-3672, 524 Fed. Appx. 164, 2013 U.S. App. Lexis 7691, 2013 Fed. App. 376N (Unpub. 6th Cir.), an arrestee who appeared intoxicated actively resisted officers both during the process of being arrested and when taken into jail. He was handcuffed and pepper sprayed. Then, at the jail, when he continued to resist, he was held down and a Taser was applied to him three times in the stun mode. He was held face down, ceased breathing, and was taken to a hospital where he died.

A medical expert for the plaintiff expressed the opinion that his cause of death was traumatic asphyxia due to compression of his neck and back while being restrained. A federal appeals court ruled that the defendant officers were entitled to qualified immunity

because there was insufficient evidence to support the strangulation theory, since only the expert's conclusory opinion supported it. That opinion was contradicted by other evidence, including the testimony of all the officers and two EMTs.

❖ Canadian Study

An important research study on the use of the neck restraints in policing was published in 2007 by the Canadian Police Research Centre. It concluded that, while it is true that no method of restraint is absolutely risk free, no medical reason exists to expect that death or serious bodily injury will ordinarily follow a correct application of a vascular neck restraint on a member of the general public by police officers who act as professionals and who have received adequate standardized training and apply the techniques they have learned.

At the same time, the study did acknowledge that certain medical conditions can increase the risk of a good number of activities, including being restrained. Most physiological abnormalities, however, are not physically apparent to the officer or others on approaching a violent person requiring restraint.

"Officers have no medical training and should anticipate that subjects fall under the characteristics of the general population unless overwhelming evidence of clues presented to the officer suggest otherwise." The study suggests attention to a number of risk groups because of the potential increased risk specific to the application of a neck restraint, and because officers with no medical training and no reliable medical information about the individual may be able to identify them. The report discusses each in some detail. The enumerated risk groups are:

1. The obvious elderly
2. Obvious pediatric subjects
3. Obvious or known Down's syndrome (Trisomy 21)
4. The obviously, visibly pregnant woman

The study found that while oleoresin capsicum (OC) is the force tool least injurious in practice, Electronic Control Weapons and the Lateral Vascular Neck Restraint (LVNR) were the next least injurious, with a full 52.9% of suspects subjected to it completely uninjured after use of a LVNR, and the vast major of the injuries suffered being minor. Three quarters of all officers emerged from the incident completely uninjured.

The study contains a wealth of discussion of medical and practical information and suggestions, and is highly recommended reading.

❖ Suggestions to Consider

The following is a discussion taken from a training bulletin published by AELE two decades ago on Use of Force Tactics and Non-Lethal Weaponry. In the full bulletin, the use of neck restraints are compared and contrasted with other use of force tactics.

Many neck holds used by officers trace their origin to sport judo. The most traditional restraint is the arm bar which applies pressure with the forearm across the front of the neck. Because this technique cuts off the victim's air supply, it has been widely rejected by police trainers. As with a drowning swimmer, the procedure sometimes precipitates resistance as the person fights for air.

The *carotid restraint* is taught by many law enforcement agencies. It involves application of the forearm to one side of the neck, and the bicep area of the arm to the opposite side of the neck. The crux of the elbow is positioned at the front of the throat, with particular care so as not to apply pressure to the esophagus.

The *(Kansas City) lateral vascular neck restraint* is distinctive, in that three levels of control are present. Unlike the carotid restraint which produces unconsciousness, this method emphasizes capturing an arrestee's balance, and the application of pressure in an escalating series of steps. The procedure is also characterized by a more dynamic "pull through" application method, than the fixed compression technique of the carotid restraint.

STRENGTHS

1. Neck restraints are effective, regardless of the size of the officer relative to the person to be controlled.
2. Unlike batons, the procedure does not require a lot of room for striking distance; it is possible to employ grappling procedures and neck restraint in close contact, in narrow or cluttered premises.
3. Neck restraints are an attempt to provide a "humane" means of controlling combative persons without the necessity of striking them, thus minimizing the risk of broken bones, lacerations, and other impact-related trauma.

WEAKNESSES

1. Neck restraints, if applied improperly, have caused death or paralysis.

2. Due to the dynamics of a violent struggle, it is often difficult to correctly apply such methods.
3. Several instances of “unexplained” death have followed purportedly proper application of the technique, unaccompanied by any discoverable physical injuries. This phenomenon, known as “custody death syndrome,” is not fully understood, and research is still ongoing.
4. Perpetual and time-consuming training is needed to maintain minimum levels of proficiency.
5. During litigation, it is difficult to precisely explain to a jury the physiological effects of neck restraint procedures, due to an inadequate base of undisputed medical evidence. Even within the medical community, there are disagreements regarding the mechanism that causes unconsciousness.
6. It is difficult for an officer to monitor and control the amount of pressure applied during the procedure.
7. Once the restraint has been applied, there is a need to closely monitor the arrestee. This may be impractical when the individual is booked into a detention facility operated by another agency.

The following are additional suggestions, written for the Jan. 2014 article:

1. Regular training on the use of neck restraints should be provided.
2. Training should include information about the potential of the restraint causing adverse medical outcomes, particularly among specific groups that may be more at risk. It has been suggested that trainees should be given a chance during the sessions to assume roles as the restrainer, the restrained, and a non-participant observer.
3. Use of the techniques taught should be restricted, as a matter of policy, to circumstances where the officers or third parties are at risk of physical injury.
4. Documentation should be created of all incidents in which neck restraints are used, and the data summarized periodically to identify issues that may require modified or additional training, as well as to monitor whether officers are adhering to departmental policy.
5. Training should include helping officers to recognize the symptoms and signs of unconsciousness so that, once identified, the officer can discontinue compression while maintaining control and applying appropriate restraints, such as handcuffs.

6. Suspects who become unconscious should be monitored for vital signs. If they do not regain consciousness within approximately 30 seconds, lifesaving measures should begin and emergency medical personnel should be summoned.
7. Suspects who complain of ongoing discomfort or pain should be allowed to seek medical attention within a reasonable time period.

❖ **Resources**

The following are some useful resources related to the subject of this article.

- Alert No. 3: Use of Force Tactics and Non-Lethal Weaponry. AELE.
- Assault and Battery: Choke Holds. AELE Case Summaries.
- Choke Holds. AELE Case Summaries.
- Chokehold. Wikipedia article.
- LVNR Staff Study. Grand Junction Police Department (Sept. 29, 2010).
- New Orleans, La. Police Department Consent Decree (Jan. 11, 2013). [Page 8 contains a definition of "neck hold" used by the U.S. Department of Justice].
- "The Resurgence of Carotid Control: Managing the Risks and Getting It Right," by Ken Wallentine.
- "The Return of the Carotid Restraint Control Hold," by Ron Martinelli.
- Town of East Haven, CT. Settlement Agreement (Nov. 20, 2012). [Page 6 contains a definition of "neck hold" used by the U.S. Department of Justice].

❖ **Prior Relevant Monthly Law Journal Articles**

- Civil Liability for Neck Restraints - Part 1, 2013 (12) AELE Mo. L. J. 101.

❖ **References:** (*Chronological*)

1. "Why the LVNR isn't a 'choke hold'," by Charles "Chip" Huth, PoliceOne (March 19, 2013).
2. "Bringing back 'the carotid,'" by Chuck Joyner, PoliceOne (July 18, 2012).
3. "Vascular neck restraint: Reprieve for a bum-rapped technique," Force Science News #198 (February 27, 2012).
4. "Mechanism of loss of consciousness during vascular neck restraint," by Jamie R.

Mitchell, Dan E. Roach, John V. Tyberg, Israel Belenkie, and Robert S. Sheldon, Journal of Applied Physiology, Vol. 112, No 3, pgs. 396-402 (Feb. 1, 2012).

5. "Bilateral vascular restraint – Facts and myths of the carotid restraint," by Dr. John Pi, M.D., Chuck Joyner, et al., NTOA.com Summer Edition, The Tactical Edge (2010).
6. "Proper use of neck hold not fatal, research shows," Las Vegas Review Journal (Nov. 27, 2009).
7. "Police use of chokeholds is a 'liability'," by Joshua Sabatini, San Francisco Examiner (Sept. 22, 2008).
8. "National Study on Neck Restraint in Policing," Canadian Police Research Centre #TR-01-2007 (January 2007).
9. "Finding a Safe Way to Subdue Violent Suspects: LAPD: The 'chokehold' ban merits rational reconsideration," by Greg Meyer, Los Angeles Times (June 14, 1994).

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